2009-2010 Regular Session
State Legislative Report as of 09/15/2009

Priority Board Bills

AB 2 (De La Torre) Rescission of Health Insurance Coverage
This bill passed the legislature and was sent to enrollment on 09/10/2009. This bill would require DMHC and CDI to establish a rescission review process and impose penalties upon plans and insurers that prolong the review process or that fail to implement the review panel's decisions, and would require that penalties be deposited into the Major Risk Medical Insurance Fund for purposes of MRMIP. For a summary of this bill see page 3 of this report.

AB 98 (De La Torre) Mandated Benefit: Maternity Coverage
This bill passed the legislature and was sent to enrollment on 09/10/2009. This bill would require individual or group health insurance policies that cover hospital, medical or surgical expenses to cover maternity services. For a summary of this bill see page 4 of this report.

AB 542 (Feuer) Hospital-Acquired Conditions
This is a 2-year bill. This bill would require MRMIB, in collaboration with the Department of Managed Health Care and other departments, to adopt new regulations and implement non-payment policies regarding hospital-acquired conditions, which was a topic addressed by AB 2146 (Feuer, 2007). For a summary of this bill see page 5 of this report.

***AB 718** (Emmerson) MRMIP Weighted Average Premium Calculation
This is a 2-year bill. This bill would redefine the "average premium" for guaranteed issue preferred provider arrangements offered to individuals pursuant to the federal Health Insurance Portability and Accessibility Act (HIPAA) and would require MRMIB to calculate these "average premiums" and provide them to the DMHC and DOI annually. For a summary of this bill see page 6 of this report.

AB 730 (De La Torre) Penalties for Unlawful Rescission of Health Insurance Policies
This bill passed the Legislature on 09/09/2009 and is on the Governor's desk. This bill would allow the State Insurance Commissioner to impose monetary penalties on health insurers who unlawfully rescind health insurance policies and would require a portion of these penalties to be deposited into the Major Risk Medical Insurance Fund to be used for MRMIP. For a summary of this bill see page 6 of this report.

AB 786 (Jones) Individual Health Insurance Coverage Categories
This is a 2-year bill. This bill is similar to SB 1522 (Steinberg, 2007). It would require DMHC and CDI, by July 1, 2012, to develop a system to categorize all individual health care service plan contracts and health insurance policies into five coverage choice categories and would limit out-of-pocket costs for covered benefits. For a summary of this bill see page 6 of this report.

AB 1383 (Jones) Increase Payments to Medi-Cal Hospitals and Fund Children's Health
This bill passed the Legislature on 09/09/2009 and is on the Governor's desk. This bill would require the Department of Health Care Services (DHCS) to calculate and impose a provider fee on specified hospitals, effective January 1, 2011, to be used for making supplemental Medi-Cal hospital reimbursements, paying supplemental payments to managed care plans, and paying for health care coverage for children. For a summary of this bill see page 7 of this report.

AB 1422 (Bass) Medi-Cal Managed Care Plan Gross Premium Tax
This bill passed the Legislature on 09/03/2009 and is on the Governor's desk. The Governor issued a press release on September 3rd saying he intended to sign the bill. It would establish a gross premium tax for Medi-Cal managed care plans and would direct a portion of the revenues to MRMIB to fund the Healthy Families Program (HFP). For a summary of this bill see page 8 of this report.

SB 227 (Alquist) MRMIP Expansion
This is a 2-year bill. This bill would, among other things, significantly alter the funding and benefit structure of the MRMIP and would expand MRMIB's role in the coverage of high-risk individuals. For a summary of this bill see page 10 of this report.

SBX3 26 (Alquist) CHIPRA Implementation
This is a 2-year bill. This bill is identical to SB 311 (Alquist, 2009), which stated the intent of the Legislature to implement key elements of the federal Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA). SB 311 died in the regular session. For a summary of this bill see page 1 of the special session report.

2009-2010 Regular Session
State Legislative Report as of 09/15/2009

Assembly Bills

AB 2 (De La Torre) Rescission of Health Insurance Coverage
Version: ***Amended 08/17/2009***
Sponsor: California Medical Association
Status: ***09/10/2009-In ENROLLMENT***

This bill is substantively the same as AB 1945 (De La Torre, 2007). The bill would require health plans and insurers to obtain prior approval from the Department of Managed Health Care (DMHC) Director and the California Department of Insurance (CDI) Commissioner, respectively, before rescinding any health coverage. It would restate existing law that allows for the cancellation or non-renewal of individual health plan contract or policy enrollments or subscriptions for failure to pay the premium. It would require the DMHC Director and CDI Commissioner, beginning January 1, 2011, to jointly establish an independent process for reviewing health plans' and insurers' requests to rescind an enrollee's coverage. It would prohibit a plan or insurer from rescinding an individual health contract or policy unless the health plan or insurer demonstrates that the enrollee "made a material misrepresentation or material omission" about his or her medical history in the application process, the misrepresentation or omission was intended in order to obtain health care coverage, the plan or insurer completed medical underwriting before issuing the plan contract and sent a copy of the completed application to the applicant with a copy of the health care contract or policy. The bill would impose administrative penalties upon plans and insurers that prolong the review process or that fail to implement its decisions and would require that penalties collected from plans be deposited into the Managed Care Administrative Fines and Penalties Fund. It would further require that penalties collected from insurers be deposited into the Major Risk Medical Insurance Fund for purposes of MRMIP, subject to appropriation by the Legislature. The bill would also permit each regulator to assess other administrative penalties and suspend or revoke a plan's license or insurer's business certificate if they rescind coverage without prior DMHC or CDI approval. It would also require DMHC and CDI to establish by regulation a pool of approved questions for use on individual coverage applications by health plans and insurers that elect to sell individual coverage, and would require the plans and insurers, no later than six months following passage of the regulation, to use only questions that are approved by the DMHC and CDI. The bill would exempt from the bill's provisions all health plan contracts with the Access for Infants and Mothers program and the Healthy Families Program. ***The amendment of 08/17/2009 did not necessitate a revision of this summary.***

AB 56 (Portantino) Mandated Benefit: Mammography Screening
Version: ***Amended 09/1/2009***
Sponsor: American College of Obstetricians and Gynecologists
Status: ***09/10/2009-ENROLLED. On the Governor's desk.***

This bill would require individual and group health care insurance policies to cover mammography screening and diagnosis beginning July 1, 2010. Current law already requires this of health care plans. The bill would add participating physician assistants to the list of providers who may refer

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* New bills since the previous Board meeting

enrollees for covered breast cancer diagnosis and screening. It would further require that health plans and disability insurers provide enrollees with information regarding recommended timelines to undergo tests for the screening or diagnosis of breast cancer. ***The amendments of 09/01/2009 did not necessitate a revision of this summary.***

AB 98 (De La Torre) Mandated Benefit: Maternity Coverage
Version: ***Amended 09/04/2009***
Sponsor: California Commission on the Status of Women
Status: ***09/10/2009-In ENROLLMENT***

This bill would require all individual or group health insurance policies that cover hospital, medical or surgical expenses and are issued, amended, renewed, or delivered on or after January 1, 2010, to cover maternity services. ***The bill would further require health insurers with pending or approved individual or group health insurance policy forms already on file with the department as of that date to submit to the department, on or before March 1, 2010, a revised policy form that provides coverage for maternity services.*** The bill excludes specialized health insurance and other specified insurance coverage.

AB 108 (Hayashi) Rescission of Individual Health Insurance Coverage
Version: Amended 07/23/2009
Sponsor: Author
Status: ***09/10/2009-ENROLLED. On the Governor's desk.***

This bill would prohibit, after 24 months following issuance of an individual contract or policy, a health care plan or insurer from rescinding an individual contract or policy for any reason, or from canceling, limiting, or raising premiums on contracts or policies due to any omissions, misrepresentations, or inaccuracies in the application form, whether willful or not. The bill states it would not limit a plan or insurer's lawful options when a subscriber makes a willful misrepresentation.

AB 235 (Hayashi) Mandated Benefit: Emergency Psychiatric Services
Version: Amended 06/11/2009
Sponsor: California Hospital Association
Status: ***09/04/2009-ENROLLED. On the Governor's desk.***

This bill would add admission or transfer to a psychiatric unit within a general acute care hospital or to an acute psychiatric hospital to those emergency services that must be provided when necessary to relieve or eliminate a psychiatric emergency medical condition. The bill would exempt Medi-Cal managed care plan contracts entered into with the State Department of Health Care Services from the bill's requirements to provide additional emergency services and care.

AB 244 (Beall) Mandated Benefit: Mental Health Services
Version: ***Amended 09/01/2009***
Sponsor: Author
Status: ***09/11/2009-ENROLLED. On the Governor's desk.***

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* New bills since the previous Board meeting

This bill would require health care service plan contracts and health insurance policies issued, amended, or renewed on or after January 1, 2010, to include the diagnosis and treatment of a mental illness for a person of any age and would define mental illness for this purpose as a mental disorder defined in the Diagnostic and Statistical Manual IV (DSM IV). The bill would exclude accident-only, specified disease, hospital indemnity, Medicare supplement ***insurance***, ~~dental-only, or vision-only health care contracts and~~ ***or specialized health insurance policies but would include behavioral health-only*** policies. It would also exclude CalPERS plans and insurers unless CalPERS purchases a plan, contract, or policy that provides mental health coverage.

AB 513 (De Leon) Mandated Benefit: Consultation and Equipment Related To Breast-Feeding
Version: ***Amended 09/01/2009***
Sponsor: WIC Association
Status: ***09/11/2009-ENROLLED. On the Governor's desk.***

This bill would require health care insurance contracts and policies that cover maternity care to also cover specified consultation and ***equipment*** or equipment rental related to breast-feeding.

AB 542 (Feuer) Hospital-Acquired Conditions
Version: Amended 06/18/2009
Sponsor: Author
Status: 06/11/2009-Senate HEALTH (needs concurrence in Assembly). ***2-YEAR BILL.***

This bill is similar to AB 2146 (Feuer, 2007). It would require the Department of Managed Health Care (DMHC), in collaboration with the State Department of Public Health (DPH), the State Department of Health Care Services (DHCS), the Managed Risk Medical Insurance Board (MRMIB), the California Public Employees' Retirement System (CalPERS), and the Department of Insurance (CDI), to adopt and implement by regulation by September 1, 2010 uniform policies and practices governing the nonpayment to a health facility for hospital acquired conditions by state public health programs. The bill would require these DMHC regulations to be consistent with those developed by the federal Centers for Medicare and Medicaid Services (CMS) and to be updated annually, beginning January 1, 2012, to reflect CMS policy changes. The bill would then require DPH, DHCS, MRMIB, CalPERS and CDI to adopt regulations that are identical or substantially similar to these DMHC regulations and would prohibit health facilities from charging patients for care and services when payment is denied by MTRMIB and its plans or by DHCS.

In addition to reporting adverse events as required by current law, this bill would require medical and nursing directors of health facilities to report hospital acquired conditions annually to their boards or similar oversight bodies and would require that contracts between health facilities and health care plans be consistent with these nonpayment policies developed by DMHC. The bill would prohibit health facilities from charging for hospital acquired conditions and would require the facilities to disclose the event to the applicable payer. The bill would require implementation

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of its measures only to the extent that federal financial participation for state health programs is not jeopardized.

***AB 718** (Emmerson) MRMIP Weighted Average Premium Calculation
Version: Amended 09/01/2009
Sponsor: Department of Managed Health Care
Status: 09/03/2009-Senate RULES (passed from Senate Appropriations). ***2-YEAR BILL***

This bill would redefine the maximum premiums for guaranteed issue preferred provider arrangements offered to individuals pursuant to the federal Health Insurance Portability and Accessibility Act (HIPAA) by health insurers regulated by the Department of Managed Health Care (DMHC) and the Department of Insurance (DOI). These premiums are currently prohibited from exceeding the "average premium" paid by a subscriber in the Major Risk Medical Insurance Program (MRMIP) who is of the same age and resides in the same geographic region. The bill redefines "average premium" as the weighted average of the MRMIP average premium based on each health plan's aggregate enrollment in MRMIP in each geographic area, and requires MRMIB to calculate these "average premiums" and provide them to the DMHC and DOI annually.

AB 730 (De La Torre) Penalties for Unlawful Rescission of Health Insurance Policies
Version: ***Amended 08/18/2009***
Sponsor: Insurance Commissioner
Status: ***09/11/2009-ENROLLED. On Governor's desk.***

This bill would allow the State Insurance Commissioner to penalize health insurers who unlawfully rescind health insurance policies in an amount up to $5,000 for each unlawful rescission. The bill would subject health insurers to a penalty of up to $5,000 for each act of post-claims underwriting. If the insurer knew or had reason to know that the act of post-claims underwriting was unlawful it would further authorize the Commissioner to increase the penalty up to $10,000 for each act or violation. ***The bill would impose these penalties in lieu of the penalty imposed by current law that is capped at $118 per violation.*** The bill would require that the civil penalties and disciplinary actions provided for in the bill be determined at a hearing in accordance with the Administrative Procedure Act. The bill would require ***the first $118 of each of these penalties to be deposited into the General Fund and the remainder of*** these penalties to be deposited in the Major Risk Medical Insurance Fund and to be used for the Major Risk Medical Insurance Program, upon appropriation by the Legislature.

AB 786 (Jones) Individual Health Insurance Coverage Categories
Version: ***Amended 08/18/2009 and 09/04/2009***
Sponsor: Health Access
Status: ***09/08/2009-Senate inactive file*** (needs concurrence in Assembly). ***2-YEAR BILL***

This bill is similar to SB 1522 (Steinberg, 2007). This bill, ***by July 1, 2012***, would require the Department of Managed Health Care (DMHC) and the California Department of Insurance (CDI) to jointly develop a system to categorize all individual health plan contracts and insurance

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* New bills since the previous Board meeting

policies ~~sold on or after September 1, 2012~~ into a total of no more than 10 coverage categories, two categories of which must be in common between the departments. It would require the categories to be based on ***actuarial values or another reasonable alternative determined by CDI and DMHC***, and would require the categories to be identified by benefit levels and out-of-pocket costs.

The bill would require all individual health care plan contracts or insurance policies issued, amended or renewed on or after January 1, 2011 to have a maximum limit of ***$5,000 per person per year*** on out-of-pocket costs for in-network providers ***and on covered emergency services. The bill would index the limit to the consumer price index. It would prohibit the family out-of-pocket limit from exceeding twice the limit on individuals. The bill would exclude premium payments or prepaid periodic charges from this out-of-pocket limit. The bill would allow these contracts or policies to include a separate limit on out-of-pocket costs for covered prescription drugs. The bill would subject these provisions to applicable federal requirements.*** ~~The maximum out-of-pocket limit for contracts and policies issued, amended or renewed on or after April 1, 2011 must be $10,000 per person, per year.~~ The bill would exempt from the foregoing provisions non-behavioral specialized plans and insurers and would also exempt government-sponsored coverage.

The bill would require DMHC and CDI to jointly develop standard definitions and terminology for covered benefits and cost-sharing provisions for all health care service plan contracts and insurance policies ~~to be offered and sold to individuals on or after September 1, 2012~~. The bill would also require the Office of Patient Advocate to maintain a web site describing ***the coverage categories and*** the contracts and policies therein.

AB 1383 (Jones) Increase Payments to Medi-Cal Hospitals and Fund Children's Health
Version: ***Amended 08/18/2009, 09/03/2009, 09/04/09, and 09/12/09***
Sponsor: Daughters of Charity Health System, California Hospital Association, California Children's Hospital Association
Status: ***This bill passed the Legislature on 09/09/2009 and is on the Governor's desk.***

This bill would require the Department of Health Care Services (DHCS) to calculate and impose on hospitals, except for designated public hospitals, a provider fee, to be sunset on January 1, 2013, and contingent on approval by the federal Centers for Medicare and Medicaid Services. The bill would require the fees to be placed into a fund to then be used to draw down federal funds. The bill would require the combined state and federal funds to be used by DHCS for making supplemental reimbursements to hospitals and managed health care plans and to provide for health care coverage for children. The bill requires that $80 million of the fee revenues be used for children's health coverage each quarter of the year.

The bill specifies the method for calculating the fee and provides the DHCS flexibility in adjusting the fee if needed. The bill would require DHCS to seek all federal approvals and waivers necessary to maximize federal financial participation and to implement the bill. The bill would become effective January 1, 2010.

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* New bills since the previous Board meeting

AB 1422 (Bass) Medi-Cal Managed Care Plan Gross Premium Tax
Version: Amended 08/25/09
Sponsor: Author
Status: ***09/08/2009-ENROLLED. On Governor's desk. The Governor issued a press release on September 3rd stating he intends to sign the bill.***

The bill would create an annual tax on Medi-Cal managed care health plans' total operating revenues, as defined. Until January 1, 2011, it would further direct ***38.1% of the tax*** to the Department of Health Care Services (DHCS) ***for Medi-Cal*** ~~sufficient revenues from this tax to ensure Medi-Cal managed care plans receive contracted payment rates that are actuarially sound and would require any remaining tax revenues to be~~ ***and 61.59%*** to the MRMIB for HFP. The bill would specify the timing, frequency and method of reporting and paying the taxes and set penalties for non-compliance. The bill would also allow DHCS to retroactively increase Medi-Cal rates and make payments to plans.

This bill would increase the Healthy Families Program (HFP) premiums for families with incomes between 150 and250 percent of the federal poverty limits (FPL). These premium increases are consistent with those approved by the MRMIB and would be effective November 1, 2009. The bill would also reaffirm the authority of MRMIB to adopt regulations to modify program requirements and operations on an emergency basis.
The bill would also allow the transfer of state First Five Commission funds from other accounts to the Unallocated Account, under certain conditions.

The bill would become effective immediately upon the Governor's signature, thereby requiring passage by 2/3 vote in each house of the Legislature.

AB 1445 (Chesbro) Visits to Federally Qualified Health Centers and Rural Health Clinics
Version: Amended 06/01/2009
Sponsor: California Primary Care Association
Status: 07/09/2009-Senate Appropriations. ***2-YEAR BILL***

The bill would require federally qualified health centers (FQHCs) and rural health clinics (RHCs) to apply to the Department of Health Care Services for an adjustment to their per-visit rate when they count as a single visit the cost of multiple encounters with health professionals that occur on the same day at a single location. It would also require FQHCs and RHCs to bill a medical visit and another health visit that take place on the same day at a single location as separate visits.

AB 1503 (Lieu) Provider Reimbursement for Unpaid Emergency Health Care Services
Version: Introduced 02/27/2009
Sponsor: Health Access, Western Center on Law and Poverty
Status: 06/11/2009-Senate Health. ***2-YEAR BILL***

This bill would adapt fair pricing provisions established for hospitals by AB 774 (Chan, 2005) to emergency physicians. The bill would also modify current criteria for providers requesting

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reimbursement from the state Maddy Emergency Medical Services Fund (Maddy Fund), which was established to partially reimburse providers for uncompensated emergency care. For patients with high medical costs (as defined by the bill) and incomes at or below 350% of the federal poverty limit, the bill would also require providers to provide a discount in fees to the patient. This discount would limit payment to the provider to the greater of the rate paid by Medi-Cal, Healthy Families Program (HFP) or other state health program in which the provider participates. With exceptions, the bill would prohibit garnishing the wages of patients receiving the providers discount or selling their primary residence. It would further require providers to notify patients who do not have third-party coverage that the patient may be eligible for Medicare, Healthy Families, Medi-Cal, California Children's Services Program or discounted payment care.

AB 1541 (Assembly Health) Implementation of CHIPRA "Late Enrollee" Provision
Version: Amended 07/23/2009
Sponsor: Assembly Health Committee
Status: ***09/10/2009-ENROLLED. On Governor's desk.***

This bill would declare the intent of the Legislature to implement a provision of the federal Children's Health Insurance Program Reauthorization Act (CHIPRA) of 2009. It would exclude an employee or eligible dependent from being considered a "late enrollee" by health plans or insurers when the individual, in addition to meeting existing criteria, requests enrollment in a health plan or contract within 60 days after termination of their enrollment in the Healthy Families Program (HFP), the Access for Infants and Mothers (AIM) or termination of their Medi-Cal program coverage. The bill would also raise the number of days from 30 to 60 that an enrolled eligible employee has in which to request enrollment for a dependent after notifying the plan or insurer of the loss or pending loss of the dependent's coverage in HFP or AIM before the plan or insurer may consider the dependent a late enrollee. Current law allows plans and insurers to exclude late enrollees from coverage for 12 months following the late enrollee's application for coverage.

ACA 22 (Torlakson) New Cigarette Tax
Version: Introduced: 4/16/2009
Sponsor: Author
Status: 04/23/2009-Assembly Committees on Governmental Organization and Revenue and Taxation. ***2-YEAR BILL***

This bill, in addition to current taxes imposed by the Cigarette and Tobacco Products Tax Law, would tax cigarette distributors $0.074 for each cigarette distributed and for the wholesale cost of tobacco products, would tax dealers and wholesalers $0.074 for each cigarette or tobacco product they stock and would impose additional taxes on cigarette and tobacco product stamps.

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Senate Bills

SB 158 (Wiggins) Mandated Benefit: Human Papillomavirus Vaccination
Version: ***Amended 08/31/2009***
Sponsor: American College of Obstetricians and Gynecologists
Status: ***09/10/2009-ENROLLED. On Governor's desk.***

This bill is similar to bills AB 16 (Evans, 2007) and AB 1429 (Evans, 2007). It would require that individual and group health care plan contracts and health care insurance policies that are amended or renewed on or after January 1, 2010, and that include coverage for treatment or surgery of cervical cancer, must also provide coverage for the human papillomavirus vaccination ***and would add physician assistants to the list of those providers authorized to make referrals for such services***.

SB 161 (Wright) Mandated Benefit: Parity Coverage for Orally-Administered Cancer Medications
Version: ***Amended 08/17/2009, 08/31/2009 and 09/03/2009***
Sponsor: Kerry's Touch African-America Breast Cancer Association
Status: ***09/11/2009-ENROLLED. On Governor's desk.***

This bill would require that health care service plan contracts and health insurance policies issued, amended, or renewed on or after January 1, 2010, and that cover cancer chemotherapy treatment, must also provide coverage for cancer medications administered orally, and specifies that such coverage must be on an equal basis with coverage provided for cancer medications administered intravenously or injected. For this purpose, the bill would require health plans and insurers to compare the percentage cost share for oral cancer medications and intravenous or injected cancer medications and apply the lower of the two as the cost-sharing provision for oral cancer medications. The bill would also prohibit health plans and insurers from increasing enrollee cost sharing for cancer medications ***at a greater rate than they increase cost sharing for other medications***. The bill would exclude CalPERS from these requirements.

SB 227 (Alquist) MRMIP Expansion
Version: Amended 07/13/2009
Sponsor: Author
Status: 07/01/2009-Assembly APPROPRIATIONS (needs concurrence in Senate). ***2-YEAR BILL***

The Board originally took a position of "support if amended" on this bill. Because the author amended the bill to cap the maximum subscriber contribution at 125% of the standard premium for comparable coverage, the Board is now in "support" of the bill. SB 227 is similar to AB 2 (Dymally, 2007) and AB 1971 (Chan, 2005). The bill would ensure long-term stable funding for the Major Risk Medical Insurance Program (MRMIP), thereby expanding the program to cover more individuals. It would accomplish this by requiring health care plans and insurers to elect to either provide guaranteed-renewable coverage to individuals eligible for the MRMIP or to pay a fee. The bill would eliminate the annual $75,000 benefit limit and would require MRMIB to increase the lifetime limit to no less than $1,000,000. The bill would also require MRMIB,

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conditioned on the absence of a MRMIP waitlist, to establish a process for individuals in the Guaranteed Issue Pilot program to voluntarily re-enroll into the MRMIP.

The bill would require MRMIB to establish premiums at no more than 125% of the standard average individual rate for comparable coverage, which is consistent with existing maximum subscriber contribution rates. Please see the July 22, 2009, letter of support included in that date's Board packet for more information on this bill.

SB 543 (Leno) Minors: Consent for Mental Health Treatment
Version: ***Amended 09/03/2009***
Sponsor: National Association of Social Workers, California Chapter; Mental Health America of Northern California; GSA Network; and Equality California
Status: ***09/11/2009-Senate INACTIVE FILE*** (needs concurrence in Senate). ***2-YEAR BILL***

The bill would allow a minor who is at least 12 years old to consent to outpatient mental health treatment or counseling services if the attending professional person, as defined, determines the minor is mature enough to participate intelligently in the mental health treatment or counseling services. The bill would require involvement of the minor's parents in the treatment or services unless the professional person determines, after consulting with the minor, that the parental involvement would be inappropriate. ***The bill would expand the definition of a professional person to include a licensed clinical social worker, as specified, and a board-certified or board-eligible psychiatrist.***

SB 630 (Steinberg) Mandated Benefit: Orthodontic Reconstructive Surgery for Cleft Palate
Version: ***Amended 09/04/2009***
Sponsor: California Society of Plastic Surgeons
Status: ***09/11/2009-IN ENROLLMENT***

This bill is similar to SB 1634 (Steinberg, 2007), which was vetoed. This bill would expand the current definition of reconstructive surgery ***as of July 1, 2010,*** to include medically necessary dental or orthodontic services that are an integral part of reconstructive surgery for cleft palate procedures, thereby requiring health plan contracts and insurance policies to cover these services. The bill would exclude Medi-Cal managed care plans that contract with the Department of Health Care Services that do not provide coverage for California Children's Services (CCS) or dental services.

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* New bills since the previous Board meeting

Bills MRMIB Will No Longer Report To The Board
After The 09/16/2009 Board Meeting

AB 1011 (Jones) Environmentally Friendly Insurance Products
Version: ***Amended 09/03/2009***
Sponsor: Author
Status: 06/18/2009-Senate FIRST READING (needs concurrence in Assembly)

This bill was amended to require all insurers to cover environmentally-favorable building materials and no longer impacts the Managed Risk Medical Insurance Board.

~~This bill states the Legislature's intent to enact legislation that would implement the provisions in AB 1383, which would impose a "coverage dividend fee" on designated hospitals, use the fee to draw down federal funds, and then use these state and federal funds to make specific supplemental Medi-Cal payments and expand health care coverage for children.~~

SB 499 (Ducheny) Hospital Seismic Safety ~~MRMIB Reporting on Use of DMHC Fines~~
Version: ***Amended 09/04/2009***
Sponsor: Author
Status: ***09/11/2009-IN ENROLLMENT***

This bill was amended to relate to hospital seismic safety and no longer impacts MRMIB.

~~This bill would require MRMIB to report to the Legislature no later than March 1, 2010, and annually thereafter, on the amount and use of fines and administrative penalty funds transferred to the Major Risk Medical Insurance Fund as a result of SB 1379 (Ducheny; Chapter 607, Statutes of 2008) and the effect of those funds on the waiting list for the Major Risk Medical Insurance Program.~~

SB 600 (Padilla) New Cigarette Tax
Version: Amended 06/09/2009
Sponsor: American Cancer Society
Status: ***08/31/2009-Passed all Committees. In Senate RULES. Bill died.***

According to the author's office, this bill is dead and will not be moved next year. This bill would create the Tobacco Tax and Health Protection Fund. It would, in addition to existing cigarette taxes, impose an additional tax upon every dealer and wholesaler of cigarettes at the rate of $0.075 for each cigarette distributed on or after the first calendar quarter commencing more than 90 days after the bill's enactment. It would further require cigarette distributors to pay a cigarette indicia adjustment tax for each California cigarette tax stamp at the rate of SL875, $1.50 or $0.75 per stamp depending on the type of stamp and would deposit these new taxes into the fund.

The bill would require that funds then be transferred from the Tobacco Tax and Health Protection Fund to the California Children and Families First Trust Fund, the Hospital Services

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Account, the Physician Services Account, the Public Resources Account, the Unallocated Account of the Cigarette and Tobacco Products Surtax Fund, and the Breast Cancer Fund, as needed to offset the revenue decrease directly resulting from imposition of the bill's new taxes. The bill would allow these funds only to supplement existing levels of service, not to fund existing levels of service.

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* New bills since the previous Board meeting